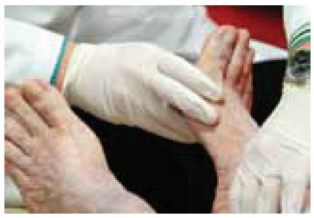
I Can Control My Diabetes By Working With My Health Care Team!

To team up with my pharmacist, I will—

- Make a list of all my medicines, the exact doses, and include over–the-counter medicines, vitamins, and herbal supplements.
- Update and review the list with my pharmacist every time there is a change.
- Ask how to take my medicine and use supplies to get the best results at the lowest cost.
- Ask about new medicines that I can talk about with my doctor.



To team up with my podiatrist, I will—

- Get a full foot exam by a podiatrist at least once each year.
- Learn how to check my feet myself every day.
- See my podiatrist right away if I develop any foot pain, redness, or sores.
- Ask about the right shoes for me.
- Make sure my feet are checked at every health care visit.

To team up with my eye care provider, I will—

- Ask for a full eye exam with dilated pupils each year.
- Ask how to prevent diabetic eye disease.
- Ask what to do if I have vision changes.

To team up with my dental provider, I will—

- Visit my dental provider at least once a year for a full mouth exam.
- Learn the best way to brush my teeth and use dental floss.
- Ask about the early signs of tooth, mouth, and gum problems.
- Ask about the link between diabetes and gum disease.

To control my diabetes every day, I will—

- Be more active—walk, play, dance, swim, and turn off the TV.
- Eat a healthy diet—choose smaller portions, more vegetables, and less salt, fat, and sugar.
- Quit if I smoke or use other tobacco products—tobacco use increases the risk of health problems from diabetes. To quit, call: 1-800-QUIT-NOW (1-800-784-8669).
- Ask all my providers to share my exam results with my other health care providers.
- Learn about managing my diabetes by visiting www.yourdiabetesinfo.org.
- Control my ABCs of diabetes:
  - **A1c**. This test measures average blood sugar levels over the last 3 months. The goal is less than 7% for many people but your health care provider might set different goals for you.
  - **Blood Pressure.** High blood pressure causes heart disease. The goal is less than 140/80mm Hg for most people.
  - **Cholesterol**. Bad cholesterol or LDL (Low Density Lipoprotein) builds up and clogs your arteries. The goal is an LDL less than 100 mg/dl.

For more FREE information on how to prevent and control diabetes call the National Diabetes Education Program (NDEP) at 1-888-693-NDEP (6337), TTY 1-866-569-1162, or visit **www.yourdiabetesinfo.org**.

NDEP is a partnership of the Centers for Disease Control and Prevention, the National Institutes of Health, and more than 200 public and private organizations.

CS232738-A NDEP-128

Diabetes Head to Toe Checklist Examination Report

Your organization's name here_____

From: | **To:**

Patient Information:

Name: _____ **DOB:** _____

Diabetes: ❑ Type 1 ❑ Type 2 ❑ Gestational ❑ Prediabetes **HbA1c Goal:** _____ ❑ < 6 months ❑ >/= 6 months ❑ Unknown

Duration of Diabetes (in years): _____ **Current Diabetes Therapy:** ❑ Insulin ❑ Oral Hypoglycemic ❑ Diet Control ❑ None

Results of Last Finger-stick blood glucose reading (per patient): _____ ❑ N/A Patient reports under control ❑ Yes ❑ No

Dietary Counseling ❑ Yes ❑ No Type of Diet: _____

MEDICINES

Date: _____

Patient has a written med list ❑ Yes ❑ No

OTC Meds Used: (if none: ❑)

Herbal Meds Used: (if none: ❑)

Pharmacist reviewed meds on (date): _____

Patient has Rx for: (provide reason if "no")

Aspirin ❑ Yes ❑ No:

Cholesterol med ❑ Yes ❑ No:

ACE inh or ARB ❑ Yes ❑ No:

Reports Side Effects to Meds ❑ Yes ❑ No

If yes, describe:

Reports hypoglycemia events? ❑ Yes ❑ No

If yes, describe:

Does patient know their current:

A1c? ❑ Yes ❑ No Goal A1c?: ❑ Yes ❑ No

LDL? ❑ Yes ❑ No Goal LDL? ❑ Yes ❑ No BP? ❑ Yes ❑ No Goal BP? ❑ Yes ❑ No

Home Glucose Monitoring Frequency:

❑ once daily

❑ twice daily

❑ 3-4 times daily

❑ Other: _____

If on insulin, list current dose:

List dosing times:

KIDNEY/HEART & VASCULAR

Date: _____

Risk factors in addition to diabetes:
(give dates for all)

Blood Pressure: Goal:_____ Measured: _____

Total, LDL and HDL cholesterol, triglycerides: (LDL goal and measured values for all)

_____

_____

Smoking status: (circle all that apply)
Never Former Current Willing To Quit

Assessments: (give dates for all)

Urine albumin-to-creatinine ratio: _____

Serum creatinine and estimated GFR:_____

_____

Potassium: _____

Hemoglobin: _____

History of myocardial infarction, heart failure, or stroke:_____

Heart or brain testing (e.g. stress test, echo, angiogram, CT scan, ultrasound, MRI): _____

History of dialysis or kidney transplant:

_____

Kidney tests (ultrasound, CT Scan, Angiogram):_____

FEET

Date: _____

Current ulcer or history of a foot ulcer? ❑ Yes ❑ No

Foot Exam: Skin, Hair, and Nail Condition

Is the skin thin, fragile, shiny and hairless? ❑ Yes ❑ No

Are the nails thick, too long, ingrown, or infected with fungal disease? ❑ Yes ❑ No

Note Musculoskeletal Deformities

❑ Toe deformities ❑ Bunions (Hallus Valgus) ❑ Charcot foot

❑ Foot drop ❑ Prominent Metatarsal Heads

Pedal Pulses - "P" for present or "A" for absent

Posterior tibial Left__ Right__ Dorsalis pedis Left__Right__

Risk Categorization check appropriate box.

❑ **Low Risk Patient**	❑ **High Risk Patient**
All of the following:	One or more of the following:
❑ Intact protective sensation	❑ Loss of protective sensation
❑ Pedal pulses present	❑ Absent pedal pulses
❑ No deformity	❑ Foot deformity
❑ No prior foot ulcer	❑ History of foot ulcer
❑ No amputation	❑ Prior amputation

EYES

Date: _____

Visual Acuity (best corrected) Right:_____ Left:_____

Intraocular Pressure Right:_____ Left:_____

❑ **Dilated Fundus Exam Performed**

Diagnosis:

No Diabetic Retinopathy ❑ Yes ❑ No

Non-Proliferative Diabetic Retinopathy ❑ Yes ❑ No

Plan:

❑ Monitor Only ❑ Repeat Dilated Exam In _____ months

❑ Additional Testing/Treatment Recommended:

Proliferative Diabetic Retinopathy ❑ Yes ❑ No

Clinically Significant Macular Edema ❑ Yes ❑ No

MOUTH

Date: _____

Examination Findings

Intraoral/Extraoral:

Caries:

Periodontal (health, abscesses, gingivitis, periodontitis):

Xerostomia:

Fungal infection:

Parotid gland changes:

Functional (eating, swallowing, etc) concerns: _____

Additional Testing/Treatment Recommended: _____

Refer to Specialist: _____ Re-evaluate in _____months(s)

Management:

❑ Follow-up:_____ months ❑ Patient education/discussion ❑ Information pamphlet given

Referral To:_____ For:_____

Other_____ Doctor's Signature_____